Separating the Haves from the Have-Nots: State Options for Targeted Application of Hospital Affordability Policies

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Peterson-Milbank
Program for Sustainable
Health Care Costs

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ABSTRACT

As states seek to tackle high commercial health care spending, high spending growth, and increasingly unaffordable care, they must consider hospital spending and prices as major contributors. In many states, policy discussions have been stymied by hospitals and their lobbyists, who argue that hospitals are struggling financially and that state action to address hospital prices will result in hospital closures and service line cuts, endangering patient access. This report describes how states can focus affordability efforts to impact highly resourced hospitals and health systems (the haves) without endangering those that would struggle to implement state commercial market affordability policies (the have-nots). It also provides options to help states identify hospitals within each group, using existing public analyses and state data where available.

INTRODUCTION

Hospital spending accounts for nearly half of health care spending nationally for people with employer-sponsored health insurance.[1] As states seek to tackle high commercial health care spending and spending growth, they must consider hospital spending and prices as major contributors.

States pursuing health care affordability strategies (like hospital price caps, price growth caps, or site-neutral payment policies) face major pushback from hospitals and their lobbying groups.[2,3,4] The certain increase in uncompensated care in the coming years (resulting from people losing their insurance due to the terms of HR1,[5] recently passed and signed into law) will increase financial pressures. Hospitals argue that these policies will have disastrous financial impacts for them and that this legislation could force them to make service cuts or even close facilities, endangering patient access to care.[6,7,8]

These arguments mask a critical truth: Not all hospitals and health systems are in the same financial position. Rather, the hospital industry is characterized by a mix of what Fredric Blavin of the Urban Institute and coauthors have referred to as haves and have-nots.[9]

Some hospitals and health systems (the haves) retain large reserves and strong market power, and others (the have-nots) are financially precarious. The haves are often large and/or located in high-income communities, whereas the have-nots are often small and/or located in low-income communities.[10,11] Historical information suggests that high-asset hospitals grow their assets particularly through nonpatient care activities, using their wealth to generate more funds, while low-asset hospitals are likely to stay low asset.[12]

This report describes how states can focus affordability efforts to impact have hospitals and health systems with substantial reserves and strong market power — frequently the largest contributors to spending growth — without endangering have-nots, which would struggle to implement state commercial market affordability policies targeting hospital spending. It also provides options to help states identify hospitals and health systems within each group, using existing public analyses and state data where available.

FOCUSING STATE POLICY ACTION ON WEALTHY, HIGH-PRICED HOSPITALS

Focusing the application of affordability policies on better-resourced institutions may be an effective strategy for states to address the largest contributors to commercial market unaffordability.

Since the start of the COVID-19 pandemic, hospitals, health systems, and their associations have made dire predictions about the future of the industry, citing challenges such as increasing labor costs and other inflationary pressures,[13] insufficient government program payment rates,[14,15,16] lack of appropriate discharge beds,[17] and aging infrastructure that requires increased capital investment.[18]

The hospital industry has faced serious challenges since 2020 and, in particular, experienced widescale losses in fiscal year (FY) 2022 as federal pandemic relief programs ended and stock market swings decreased investment portfolio values.[19,20] Though industry-wide financial performance has improved since then, with gradual recovery starting in late FY2023 and continuing in FY2024,[21,22,23] some hospitals continue to struggle.

However, these challenges have not been felt evenly. While some hospitals and systems have seen degradation of their finances (e.g., poor margins, low liquidity, and downgraded credit ratings), others have maintained robust financial health, maintaining significant reserves and high credit ratings.[24,25]

Many states have a small number of dominant health systems[26] — one or two per market — with large patient volumes, strong market power, and robust finances.[27] Many of these large, dominant systems appear well positioned to continue growing and expanding.[28,29,30] Evidence shows that this strong market power is associated with higher commercial prices.[31] Because of their large patient volumes, market dominant hospitals can have an outsize impact on health care cost growth. Focusing the application of affordability policies on better-resourced institutions may be an effective strategy for states to address the largest contributors to commercial market unaffordability.

Conversely, states should consider offering narrow exemptions from affordability policies, potentially including very small hospitals and hospitals that are in very poor financial shape.[32] This approach benefits at-risk hospitals and health systems; it spares them from sudden decreases in revenue that could result from a new hospital price policy.

Additionally, states could make targeted investments in financially disadvantaged hospitals, comparatively low-priced providers, or other priority provider types (e.g., primary care, behavioral health) or services (e.g., rural obstetric care) with the savings generated from hospital affordability policies.

There are some limitations to this targeted approach. It may result in a smaller total impact on commercial market affordability. The impact on consumers — particularly regarding consumer cost sharing and out-of-pocket spending — would also be uneven. For example, if states cap

prices at have hospitals, those consumers could expect a reduced cost-sharing burden for services, while consumers seeking care at exempt have-not facilities would not receive this benefit.

No matter what affordability policies states pursue, they should expect significant pushback from the industry. Hospitals and their associations will argue against these strategies by suggesting that the policies could result in cuts to services or facility closures, for example. They will also cast doubt on states' methods of analysis, data sources, and criteria used to permit exemptions. Clearly defining data sources and methods, and using objective exemption criteria will be important for ensuring state initiatives can withstand opposition.

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Despite these likely challenges, it is worthwhile for states to pursue cost containment focused on have hospitals. Many of the following policies can generate significant savings for states and consumers, even with the accompanying exemptions for have-not hospitals.

STATE OPTIONS FOR TARGETED APPLICATION OF HOSPITAL AFFORDABILITY POLICIES

States have a variety of policy options to address the expense of hospital services and hospital care's contribution to high and growing overall health care spending.[33] Some of these options are particularly ripe for focused application to financially advantaged hospitals, including (1) price caps and/or price growth caps, (2) measurement and reporting of hospital price growth, and (3) site-neutral payments and limitations on outpatient facility fees. As outlined in the following list, states can consider limiting the application of these policies based on hospital financial status, either by exempting some facilities or by implementing a tiered approach.

1. **Price caps and/or price growth caps.** Price caps, also known as "reference-based pricing," set a maximum amount that hospitals can be paid for a service, often a percentage of an individual hospital's Medicare payments for that service. Price growth caps do not set a cap on prices themselves but limit how much prices can increase annually; this amount is usually tied to measures of inflation or, where applicable, a state's cost growth target. States could apply a price cap and/or price growth cap through insurance regulation (e.g., as a condition of rate review approval) or through provider regulation (e.g., as a direct requirement for hospitals), depending on existing authorities. States can also use their purchasing authority when administering public employee health benefit programs or leverage other state authorities.

    - **Opportunities for a targeted approach.** States could consider limiting a price cap and/or price growth cap approach by exempting hospitals that meet criteria demonstrating that they are financially disadvantaged or do not meet a state-determined threshold for size. States could also use a tiered approach, setting higher price caps or growth caps for have-not hospitals.

    - **State examples.** Oregon has used a hospital price cap for its public employee and teachers' health plans since 2019. It is set at 185% of Medicare rates for provider and facility services. Oregon exempts critical access hospitals, as well as certain sole community hospitals.[34] A recent evaluation found that Oregon's price cap saved $107.5 million in its first 27 months of implementation, that the policy had no impact

on hospital participation in the plans' networks, and that the policy did not result in cost shifting via price increases for other commercial plans.[35]

In anticipation of establishing prospective hospital budget review, Delaware has instituted a temporary hospital price growth cap for calendar years 2025 and 2026. The cap limits most hospitals' year-to-year price growth to the greater of 2% or the Consumer Price Index plus 1%.[40]

Starting in January 2026, Vermont will cap prices on outpatient physician-administered drugs;[36] Vermont will also begin implementing price caps for hospital services across the commercial market, starting in September 2026.[37] Washington will institute a price cap for the public employee health plan in 2027.[38] In its 2025 session, the Indiana General Assembly applied a cap by passing a law stating that hospitals with prices that remained above the state average by mid-2029 forfeit their nonprofit status for at least one year.[39]

2. **Measurement and reporting of hospital price growth against a target.** A hospital price growth target represents a maximum amount which annual hospital price growth should not exceed. Rather than capping price growth through regulation, this policy introduces a public expectation for price growth. This should be accompanied by transparent state measurement of hospital price growth, public and policymaker education, and communications strategies to create incentives for hospitals and health systems not to exceed the target.

    - **Opportunities for a targeted approach.** States could exempt certain hospitals from hospital price growth target measurement entirely or publicly report performance against the target only for have facilities.

    - **State examples.** While some states compare hospital prices to an external reference, like Oregon with Medicare,[41] and other states are contemplating a hospital price growth target, no state currently implements this strategy.

3. **Site-neutral payments and limitations on outpatient facility fees.** Site-neutral payment policies limit hospitals' ability to charge higher prices than nonhospital providers for services that can be safely provided in either hospital outpatient departments or in nonhospital settings, such as physician offices. Some of the price difference is caused by hospital facility fees, meant to compensate hospitals for overhead and other costs; these fees are not charged in non-hospital-owned physician offices. These extra fees can increase costs for patients and contribute to overall health care costs. They also encourage hospitals to purchase physician practices, increasing health care consolidation. Policies that limit or ban facility fees for some outpatient services prevent hospitals from charging additional amounts on top of payments for medical care.

    - **Opportunities for a targeted approach.** States could exempt hospitals that meet criteria demonstrating that they are financially disadvantaged and/or very small hospitals. States could also direct site-neutral payment policies or limitations or bans on facility fees at particularly high-priced hospitals.

    - **State examples.** Multiple states — including Colorado,[42] Connecticut,[43] and Indiana[44] — have recently enacted policies meant to ensure site-neutral payments and/or limit hospitals' ability to charge facility fees for some outpatient services.

USING DATA TO IDENTIFY HAVE AND HAVE-NOT HOSPITALS

Completing full analyses of hospital financial data via audited financial statements is a complex undertaking and typically requires training and expertise. In some instances, Medicare cost report data gathered through the user-friendly National Academy for State Health Policy Hospital Cost Tool[45] can support this work, though there are downsides to relying on Medicare cost reports for hospital and health system financial data.[46] Furthermore, there is no one measure that fully captures a hospital's financial status; financial ratios can often tell conflicting stories of strength in some areas and weakness in others.[47]

While some states have robust teams that collect, analyze, and report hospital financial data, others do not. In the long term, state agencies may be able to expand their financial analysis expertise by leveraging existing banking and insurance regulatory processes and by learning from other states' processes. In the near term, states need multiple paths for identifying have and have-not hospitals that accommodate varied staff (or contractor) skills and bandwidth to perform deep-dive analyses.

This section presents two options for states to identify have and have-not hospitals. Each metric, along with suggested thresholds, access instructions, and considerations for interpretation are detailed in Table 1.[48] Analysts should strive to identify have and have not hospitals at the health system level — including owned hospitals, physician groups, other provider types, and the parent corporation — to capture how health systems move cash and investments, expenses, and debt between owned entities. In addition, system-level analysis captures cross-subsidization, in which some owned entities keep others afloat.

Identifying Have and Have-Not Hospitals: A Basic Method

The basic method of identifying advantaged and disadvantaged hospitals and health systems relies on largely publicly available data and analysis. It focuses on one metric — credit rating, where available — and adds additional factors to help states contextualize credit rating findings.

- **Credit rating.**[49] The three major credit rating agencies (Fitch Ratings, S&P Global, and Moody's) evaluate organizations seeking to finance long-term debt on the public bond market, including most nonprofit hospitals and health systems. For independently rated hospitals and health systems, a credit rating can provide a reliable indication of overall financial performance. In addition to employing highly skilled analysts with deep industry knowledge, credit rating agencies have significant access to hospital financial and management data, often more detailed than publicly available audited financial statements. Measures of liquidity — sometimes referred to as reserves or financial flexibility — are key factors considered by the major rating agencies.[50] Hospital and health system performance on this and other key rating agency criteria are often described in detail in rating commentaries, some of which are publicly available.

Note that not all hospitals and health systems receive ratings from the major rating agencies. Small hospitals, those with poor financial health, and hospitals that do not access debt on the public bond market (e.g., private-equity-owned hospitals) are often not rated and cannot be assessed using this basic method.

Additional Factors to Contextualize Hospital and Health System Credit Ratings

States can pair credit ratings with additional data to assess which have hospitals have the largest impact on commercial health care affordability by examining commercial prices and commercial payer mix.

- **Commercial prices.** High commercial prices suggest that a facility or system can exert significant bargaining power in contracting with commercial carriers. States that have performed commercial-market-level repricing analyses can assess commercial price variation across health systems and hospitals. Others could look to the RAND Hospital Price Transparency Study,[51] currently in its fifth round. RAND uses voluntarily contributed claims data from state all-payer claims databases, commercial insurers, and self-insured employers to study commercial payments to hospitals. The most recent data, using claims from 2022, found that commercial prices nationally averaged over 250% of Medicare rates, though there is significant state variation: Some states had average commercial prices below 200%, and others exceeded 300%.

- **Commercial payer mix.** High commercial prices are unlikely to make a meaningful contribution to overall health care spending where hospitals or health systems serve very few commercially insured patients. In addition to assessing commercial price as a percentage of Medicare rates, states should consider the percentage of hospital or system net patient revenue that comes from commercial payers as a secondary factor.

While review of credit rating plus consideration of these contextual factors do not constitute a full financial analysis of a hospital or health system, they can provide states with strong signals that a hospital is in a healthy financial position and is in good shape to bear state action to improve commercial market affordability — or that the opposite is true. States using this basic method should note that it may be more vulnerable to criticism than the more comprehensive approach outlined in the next section. They may need to refute detailed analysis of other data sources (such as audited financial statements or Medicare cost reports) by hospitals, health systems, and their associations seeking to claim that have hospitals are not, in fact, financially advantaged.

A More Comprehensive Approach to Identifying Have and Have-Not Hospitals

For a deeper view of hospital financial health, analysts should build on the basic method using state-collected standardized hospital financial statement data, where available, and/or hospital audited financial statements. States with the staff expertise and resources to perform a more comprehensive hospital financial assessment should consider Days Cash on Hand (a reflection of reserves that are available for spending on operations) and Operating Earnings Before Interest, Taxes, Depreciation, and Amortization (EBITDA) Margin and Total EBITDA Margin.

- **Days Cash on Hand.** The accumulation of significant unrestricted reserves, whether expressed as a dollar amount (unrestricted cash and investments) or as a multiplier of daily operating expenses (Days Cash on Hand, all unrestricted sources), is a critical indicator of overall financial performance — and, in particular, of hospitals' ability to weather financial challenges, including state action to improve affordability. These measures should always be calculated at the health system level

for system-owned hospitals. Health system financial practices often include keeping cash, investments, and debt at the system level, so analysts looking at individual facilities may risk underestimating financial health.

- **Operating EBITDA Margin** and **Total EBITDA Margin**. Operating EBITDA Margin — profit from providing patient care, excluding tax and financing factors (e.g., interest, depreciation, and amortization) — helps us understand whether the hospital or health system is profitable based on its core business. Total EBITDA Margin broadens this analysis to include non-operating income and expenses. While profitability is a core financial metric, many organizations regularly have positive years and negative years; averaging performance over multiple years is helpful in assessing longer-term performance.

Additional Measures for State Consideration

In addition to these measures of liquidity and profitability, states that prefer the most comprehensive approach should delve into measures of hospitals' and health systems' solvency and capital investment to get the fullest picture of financial performance.

- **EBITDA Debt Service Coverage** and **Long-Term Debt to Capitalization**. These measures of debt capacity and solvency assess hospitals' and health systems' ability to make principal and interest payments on their current long-term debt (EBITDA Debt-Service Coverage) and compare hospitals' level of debt to total available assets (Long-Term Debt to Total Capitalization). Income far in excess of required payments and debt that is a small percentage of total available assets are indicators of good financial performance. Likewise, very low EBITDA Debt Service Coverage or very high Long-Term Debt to Total Capitalization indicate very high levels of borrowing compared to available income and cash, and may be cause for concern.

- **Capital Expenditures to Depreciation** and **Average Age of Plant.** These measures of capital investment indicate whether hospitals and health systems are investing sufficiently in buildings, equipment, and infrastructure.

As with the basic method, states should consider performance in totality and not make a summary assessment of health system performance based on one metric alone. Hospitals and health systems often demonstrate mixed performance on these measures. Nonetheless, consistently high Days Cash on Hand — even when organizations show some operating losses — can often indicate robust finances, with some exceptions (e.g., very high debt load or very low capital investments). States should engage staff or contractors with sufficient expertise to make a final judgment of financial status, especially when performance is inconsistent across measures or over time.

For descriptions of these measures, a more thorough discussion of the relationships between measures, and reference ranges based on industry medians, see the Guide to Understanding Hospital Spending through Financial Analysis.[52] The guide also includes an overview of audited financial statement analysis and an Excel template to guide state analysts in standardizing hospital and health system financial statements and producing the financial ratios described under "Additional Measures for State Consideration."[53]

CONCLUSION

In seeking to pursue hospital accountability for high and growing prices, states are rightfully attentive to variation across their hospitals: in size, services provided, populations served, and finances. This report aims to support states seeking to tailor their work on hospital affordability by considering financial status. It offers policy options for implementing hospital accountability strategies that incorporate exclusions or a tiered approach, and two methods for identifying financially advantaged and financially challenged hospitals and health systems.

The key indicators described in Table 1 correlate with strong financial performance and market power (See Table on page 12). This report recognizes that analyzing and drawing conclusions from hospital financial data require significant expertise and time, but states are encouraged to perform deeper analyses if experienced analysts are available and/or hospitals face mixed financial conditions.

The measurement options proposed in this report offer paths for states with varied capacity and expertise in this area. With public data sources (like credit rating agency analyses, RAND's Hospital Price Transparency Study, and hospital and health system audited financial statements), states can pursue targeted approaches to hospital affordability policies.

By focusing state affordability policies on wealthy hospitals, states can advance their affordability goals without endangering hospitals with truly precarious finances.

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Table 1: Key Indicators of Hospital and Health System Financial Advantage

Data Element	Description
Basic Method	
Credit Rating *Source:* Credit rating agency websites: Fitch Ratings S&P Global Moody's	Suggested thresholds. • Advantaged. Credit rating indicated as "high quality" within the agency's rating scale (AAA, AA, or A for Fitch and S&P; Aaa or Aa for Moody's). • Financially challenged. Credit rating indicated as "below investment grade" (BB to D for Fitch and S&P; Ba to C for Moody's); not-for-profit hospitals with no independent credit rating or rating revoked by rating agencies. Fitch[54] and S&P[55] both use a scale of AAA (highest) to D (lowest) to rate organizations. Ratings AAA to BBB are considered investment grade, with low to moderate credit risk; BB to D are considered speculative grade and bring higher risk. Each rating category can include an additional +/- modifier (e.g., AA-). Moody's[56] uses a scale of Aaa (highest) to C (lowest), with numeric modifiers 1-3 applied to categories Aa to Caa (e.g., Baa3). Ratings Aaa to Baa are considered investment grade; ratings Ba to C are considered speculative grade. *Accessing credit ratings.* Credit rating information for not-for-profit hospitals and health systems are often accessible on major rating agency websites. While paid subscriptions are often required to access the full breadth of resources and ratings produced by rating agencies, many make some analysis publicly available. Fitch, for example, produces "rating action commentaries," which are often available publicly and include both the credit rating and the agency's supporting analysis. In addition, credit ratings and rating commentaries are sometimes available through the same national sources in which audited financial statements are housed: the Electronic Municipal Market Access (EMMA) system, a free source of financial information for large nonprofit hospitals, and the Digital Assurance Certification (DAC) Bond, which helps municipal bond issuers, including hospitals, meet their ongoing disclosure requirements. Instructions for accessing these repositories are included in the Guide to Understanding Hospital Spending through Financial Analysis, Appendix B.[57] *Considerations.* When reviewing credit ratings to assess hospitals' and health systems' level of financial advantage or disadvantage, consider the following: • Credit ratings are not available for all hospitals. Small hospitals, those that are not system owned, and those with poor financial health are less likely to be rated. Independently rated hospitals and health systems (those with ratings from the major credit rating agencies) tend to be in better financial positions than those without credit ratings. In addition, some hospitals that do not access debt on the public bond market are not independently rated; this often includes private equity-owned hospitals and systems. • Some hospitals and health systems insure their debt. When this is the case, the credit rating for that bond issuance is based on the rating of the insurer, not the underlying financial performance of the hospital or health system. However, reviewing rating agency analyses and commentaries can still offer states valuable perspective on financial performance. • Similarly, credit ratings for health systems and hospitals owned by city or county governments (public hospitals) are often based on the rating of the government entity that owns the health system or hospital, not the performance of the entity itself. • Credit ratings help assess whether an entity can repay its debts; rating agencies' analysis and commentary regarding areas of strength or concern reflect this purpose. The financial performance thresholds that credit analysts rely on when assessing financial strength may not represent ideal levels from a policy perspective.

Additional Factors to Contextualize Hospital and Health System Credit Ratings

Commercial Prices

Source: RAND Hospital Price Transparency Study

Suggested thresholds.

- Advantaged. Commercial prices above 250% of what Medicare would have paid each facility, or the state's median. The dual threshold proposed here will identify hospitals with high commercial prices from an absolute perspective (greater than 2.5 times Medicare's prices for the same services at the same facility) and identify those that are high compared to other hospitals in the state, indicating stronger bargaining power in commercial contracts.
- Financially challenged. Commercial prices below 150% of what Medicare would have paid each facility (noncritical access hospitals only).

Accessing commercial price data. Some states may conduct or procure commercial claims repricing studies that compare each commercial payment to what Medicare would have paid for the same service at the same facility. States can also look to the RAND Hospital Price Transparency Study, which calculates and publishes relative price data for over 4,000 U.S. hospitals. The study's most recent report, with findings from Round 5.1, uses claims data from 2022. In addition to a narrative report summarizing its findings, RAND publishes a Supplemental Materials Annex (download link), which includes an Excel file with complete results for hospitals (see "Table 1. Hospitals") and for some health systems (see "Table 3. Systems").

Considerations.

- RAND calculates multiple versions of relative price for different combinations of services (e.g., inpatient facility, outpatient facility, professional services). This report proposes that states use "relative price for inpatient and outpatient services," which includes both facility and professional payments. Alternatively, analysts may choose to calculate combined inpatient and outpatient facility-only relative price by dividing "total private allowed amount for facility inpatient and outpatient services ($ millions)" by "simulated Medicare allowed amount for facility inpatient and outpatient services ($ millions)."
- RAND calculates relative price at the system level for some health systems. States should use data from "Table 1. Hospitals" in RAND's Supplemental Materials Annex to review system affiliations for in-state hospitals and ensure accuracy of health system affiliations before using system-level relative price data.
- A higher relative price does not necessarily indicate higher absolute commercial reimbursements. RAND relative price reflects underlying Medicare hospital payment methodologies (e.g., the Inpatient and Outpatient Prospective Payment Systems; Medicare's critical access hospital payment methodology), which include hospital-specific adjustments for factors like medical education expenses and uncompensated care.
- Because of their "cost plus" Medicare payment methodology, critical access hospitals often receive higher payments from Medicare than from other payers, and have relative prices below 100%. Therefore, states should not use a comparison to Medicare to assess critical access hospital commercial payment amounts.
- Publicly owned hospitals sometimes show a high RAND relative price but very low commercial volume. This is often due to emergency department visits for commercially insured patients, as public hospitals are less likely to contract with commercial health plans.
- RAND's dataset is not equally robust across all states. Low employer participation and/or lack of state all-payer claims data can lead to limited data from in-state insurers. For states with limited data, relative prices are more likely to reflect rates paid by nonresident patients for out-of-network care, which can result in very high relative prices. Analysts can assess the completeness of the RAND dataset for their state by comparing data elements published by RAND with state-based data sources.

Commercial Payer Mix *Source:* State-collected hospital and health system data, where available; audited financial statements	Suggested thresholds.[58] • Advantaged. More than 50% of net patient revenue from commercial payers. • Financially challenged. More than 20% of net patient revenue from Medicaid and self-pay and/or less than 30% of net patient revenue from commercial payers. *Assessing payer mix.* Payer mix is often included in standardized financial data that some states require hospitals and health systems to submit. Where available, this is the best data source for payer mix because it ensures that payer mix is calculated using consistent payer categories and a standard denominator (net or gross patient revenue). Where this data is not available, states should use credit rating agency assessments of payer mix (see the "Basic Method" section in this table) or hospital or health system audited financial statements (noting that payer categories and the denominator will vary). For the majority of hospitals and health systems, including nearly all not-for-profits, audited financial statements can typically be accessed through EMMA and DAC Bond, and the Federal Audit Clearinghouse. Instructions for accessing these repositories are included in the Guide to Understanding Hospital Spending through Financial Analysis, Appendix B. *Considerations.* • Analysts should consider payer mix as a supplemental factor in identifying financially advantaged hospitals. For example, a hospital with a moderate credit rating and low commercial price but a high commercial payer mix may not truly be advantaged. • If using audited financial statements to assess payer mix, note that payer mix categories vary in ways that can make comparison to rating agency norms challenging. For example, some financial statements include Medicare Advantage plans in a "Medicare" category, while others may include these plans in a "Commercial and Managed Care" category. Further, it is not always clear what payers and plan types each category includes, particularly regarding Medicare Advantage and Medicaid managed care plans. • Payer mix calculated as a percentage of gross patient revenue, utilization, or volume does not reflect actual payment amounts. These are less relevant metrics for evaluating the financial impact of a hospital or health system's payer mix.
Comprehensive Method (in addition to Basic Method measures)	
Days Cash on Hand *Source:* State-collected hospital and health system data, where available; audited financial statements	Suggested threshold.[59] • Advantaged. More than 200 Days Cash on Hand, calculated as a rolling three-year average. For system-owned hospitals, analysts should assess this at the health system level. • Financially challenged. Fewer than 75 Days Cash on Hand, calculated as a rolling three-year average. For system-owned hospitals, analysts should assess this at the health system level. *Assessing Days Cash on Hand.* In states that require hospitals and health systems to submit standardized financial data for state review, Days Cash on Hand is often a calculated ratio. When this data is not available, states will need to analyze and standardize hospital or health system audited financial statements to accurately calculate Days Cash on Hand. For the majority of hospitals and health systems, including nearly all not-for-profits, audited financial statements can typically be accessed through EMMA, DAC Bond, and the Federal Audit Clearinghouse. Instructions for accessing these repositories are included in the Guide to Understanding Hospital Spending through Financial Analysis, Appendix B. *Considerations.* • Analysts should ensure that all sources of cash and investments, including board-designated assets — which may be earmarked for particular uses (e.g., capital projects) but are not legally obligated (e.g., debt reserves) — are included when calculating Days Cash on Hand. This may require analysis of audited financial statement footnotes. • Where financial statements show a major influx of cash compared to prior years, analysts should assess whether this is the result of taking on new debt in preparation for a major capital project. • Analysts should note that for-profit hospitals and health systems typically keep very few Days Cash on Hand (fewer than 10 days). • Analyzing audited financial statements to calculate Days Cash on Hand and other financial metrics is time intensive and requires experienced staff analysts. For states with dozens of hospitals and health systems, or without suitable internal knowledge or resources to hire experts, such comprehensive analysis may not be feasible. States in this position could consider limiting their review to hospitals identified as potentially advantaged or financially challenged, according to the basic method described earlier.

Operating EBITDA Margin and Total EBITDA Margin *Source:* State-collected hospital and health system data, where available; audited financial statements	Suggested thresholds.[60] • Advantaged. Average Operating EBITDA Margin greater than 8% and/or average Total EBITDA Margin greater than 10% over 3-5 years. • Financially challenged. Average Operating EBITDA Margin less than 2% and/or average Total EBITDA Margin less than 0% over 3-5 years. *Assessing margin.* In states that require hospitals and health systems to submit standardized financial data for state review, Operating and Total Margin are often calculated ratios. When these are calculated using net income rather than EBITDA, states often possess data that can be used to calculate EBITDA margins. When state standardized financial data are not available, states will need to analyze and standardize hospital or health system audited financial statements to accurately calculate Operating and Total EBITDA Margins. For the majority of hospitals and health systems, including nearly all not-for-profits, audited financial statements can typically be accessed through EMMA, DAC Bond, and the Federal Audit Clearinghouse. Instructions for accessing these repositories are included in the Guide to Understanding Hospital Spending through Financial Analysis, Appendix B. *Considerations.* • Measures of margin can vary significantly from year to year; analysts should consider average margin and trends over time (3-5 years). • Analysts should exclude unrealized gains and losses from Total EBITDA Margin calculations. These are changes in the value of an entity's investment portfolio, representing investment assets that have not been sold. Changes in portfolio value, if included, can significantly distort Total EBITDA Margin calculations. • Analysts should also identify and exclude nonrecurring income and expenses that could artificially inflate or deflate margins (e.g., sale of assets resulting in significant one-time income, government stimulus funds). • Low or negative margins can be offset by significant gifts and donations and by particularly large endowments or reserves.
Additional Measures for State Consideration	
Measures of Debt Capacity and Solvency: EBITDA Debt-Service Coverage Long-Term Debt to Capitalization *Source:* State-collected hospital and health system data, where available; audited financial statements	Suggested thresholds.[61] • Advantaged. EBITDA Debt-Service Coverage greater than 3 and Long-Term Debt to Capitalization below 35%. • Financially challenged. EBITDA Debt-Service Coverage below 1.1 (the minimum level required by most bond agreements) or Long-Term Debt to Capitalization above 50%. *Considerations.* • High Long-Term Debt to Capitalization is typically an unfavorable financial indicator. However, if an entity also has high (favorable) Debt-Service Coverage, this can indicate high cash flow from operations and the ability to shoulder the high debt load.
Measures of Capital Investment: Capital Expenditures to Depreciation Average Age of Plant *Source:* State-collected hospital and health system data, where available; audited financial statements	Suggested thresholds.[62] • Advantaged. Average Capital Expenditures to Depreciation greater than 120% over 3-5 years or Average Age of Plant under 10 years, except for hospitals or health systems that do not own their buildings and/or land. • Financially challenged. Capital Expenditures to Depreciation below 105% (average over 3-5 years) or Average Age of Plant greater than 15 years may indicate that a hospital or health system is not replacing aging assets or investing in new technologies in ways that will keep it competitive. *Considerations.* • Some hospitals — particularly private equity-owned hospitals that have sale/leaseback arrangements of core hospital assets, and government-owned hospitals — may not own their buildings and/or land. These entities can have an extremely low Average Age of Plant because they are not recording depreciation expense on these assets.

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Fitch Ratings. U.S. not-for-profit hospitals. S&P Global. Criteria | Governments. Moody's Ratings. Rating methodology.

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Total margin. Fitch Ratings considers Total EBITDA Margin of more than 11% to be appropriate for its two highest rating categories and Total EBITDA Margin of less than 7% to be appropriate for its speculative grade ratings. S&P classifies Total EBIDA Margin (after tax expense) of more than 14% as very strong or extremely strong and one below 10.5% as vulnerable or highly vulnerable for standalone hospitals. The thresholds are more than 11.5% and less than 7%, respectively, for health systems. Moody's does not use Total Margin in its rating criteria.

Fitch Ratings. U.S. not-for-profit hospitals. S&P Global. Criteria | Governments. Moody's Ratings. Rating methodology.

[61] *EBITDA Debt-Service Coverage.* Fitch considers EBITDA Debt-Service Coverage of 0.2 in excess of the debt issuer's required covenant to be neutral. S&P Global and Moody's do not use EBITDA Debt-Service Coverage in their rating criteria.

Long-Term Debt to Capitalization. Note that lower Long-Term Debt To Capitalization is considered better performance. Fitch does not consider Long-Term Debt to Capitalization in its rating criteria. S&P classifies Long-Term Debt to Capitalization of less than 35% as very strong or extremely strong and more than 50% as vulnerable or highly vulnerable for standalone hospitals. The thresholds are less than 27% and more than 55%, respectively, for health systems. Moody's does not use Long-Term Debt to Capitalization in its rating criteria.

Fitch Ratings. U.S. not-for-profit hospitals. S&P Global. Criteria | Governments. Moody's Ratings. Rating methodology.

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Average Age of Plant: Note that lower Average Age of Plant is considered better performance. High interest rates may impact health systems' ability and willingness to finance capital projects, which may lead to higher average age of plant ranges. At Fitch, an Average Age of Plant that is fewer 10 years, accompanied by high capital expenditures to depreciation, indicates "moderate capital lifecycle needs"; an Average Age of Plant more

than 13, accompanied by low Capital Expenditures to Depreciation, indicates significant need for capital investment. S&P Global considers an Average Age of Plant that is fewer than 10 years to be very strong or extremely strong and one of more than 12 years to be vulnerable or highly vulnerable for standalone hospitals. The thresholds are fewer than 10.5 and more than 12.5, respectively, for health systems. Moody's does not include specific thresholds for Average Age of Plant in its rating criteria.

Fitch Ratings. U.S. not-for-profit hospitals. S&P Global. Criteria | Governments. Moody's Ratings. Rating methodology.

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Before joining the State of Vermont, Sarah was a staff member at the National Academy for State Health Policy (NASHP). At NASHP, her work focused on state patient-centered medical homes and accountable care activity with a focus on multi-payer efforts. Sarah earned a Bachelor of Arts degree in Health: Science, Society, and Policy from Brandeis University and a Master of Public Health from the Dartmouth Institute for Health Policy and Clinical Practice.